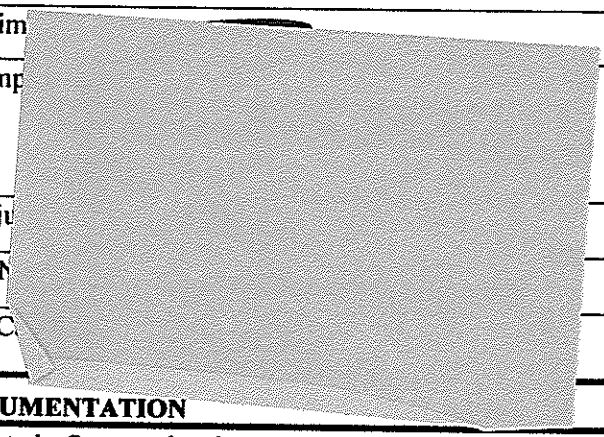
Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: John Psutka, MD P.O. Box 2135 Van Alstyne, TX 75495	MFDR Tracking #: M4-08-3655-01 DWC Claim Injured Emp
Respondent Name and Box #: Insurance Co. of the State of PA Rep. Box # 19	Date of Inju Employer N Insurance C



PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Claims never paid. Never finally adjudicated. Sent again after claim # was assigned & AIG denied past filing.

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Total Amount Sought - $000.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The $315.00 in dispute represents treatment not associated with the compensable injury, of treatment that was not billed timely."

Principle Documentation:

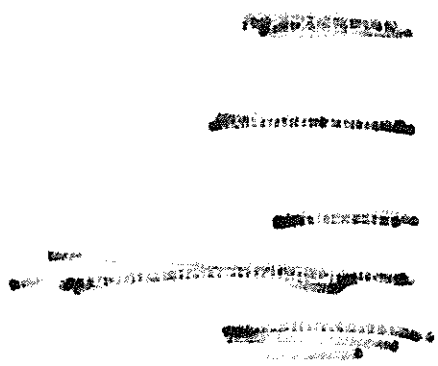
1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	CPT Code(s) and Calculations	Denial Codes	Part V Reference	Amount Due
3-13-07	99213	W11, 172	1-4	$70.04
3-13-07	90772	W11, 172	1-3, 5	$22.00
3-13-07	J2550	W11, 172	1-3, 7	$2.04
3-13-07	J2300	W11, 172	1-3, 8	$1.76
4-5-07	99214	W11, 172	1-3, 6	$106.36
Total Due:				$202.20

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines,* and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.



1. These services were denied by the Respondent with reason code "W11-Entitlement to benefits. Not finally adjudicated; and 172-Payment is adjusted when performed/billed by a provider of this specialty."

2. The Contested Case Hearing decision determined that the compensable injury of 10-1-06 extends to and includes post-concussion syndrome, cervical strain, pinched nerve in the neck, low back strain, and contusion of the right knee." The diagnosis used on the submitted CMS-1500 was 722.2- Displacement of intervertebral disc site unspecified, without myelopathy. Therefore, the disputed treatment was for the compensable injury and the EOB denial of "W11" is not supported.

3. The Requestor is a medical doctor; therefore, the EOB denial of "172" is not supported.

4. The disputed services will be reviewed in accordance with Rule 134.202. Per Rule 134.202(b), the maximum allowable reimbursement, (MAR), is determined by locality. A review of Box 32 on CMS-1500 indicates that the zip code 75495 is the locality. This zip code is located in Grayson County. The MAR for CPT code 99213 in Grayson County is $70.04, this amount is recommended.

5. The MAR for CPT code 90772 in Grayson County is $22.00, this amount is recommended.

6. The MAR for CPT code 99214 in Grayson County is $106.36, this amount is recommended.

7. Per Rule 134.202(c)(2), HCPCs code J2550 has a MAR of $2.04, this amount is recommended.

8. Per Rule 134.202(c)(2), HCPCs code J2300 has a MAR of $1.76, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $202.20 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER / DECISION:

Authorized Signature | Medical Fee Dispute Resolution Officer | 4-22-08 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.